eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the Irham Medical Center Arjan

Patent Name: **SAMUELE CASTAGNA** Gender: Male Validity Between: 01/12/2023 and 05/07/2024 **Coverage Information** 9/12/1995 12:00:00 Card No: 3740-83A3-001F-F9E1 DOB: **Out Patient** AM for: RN UAE (Al Ansari-AUH)-**Identty Card:** Pin #: Network: **MEDGULF** 784-1995-7279732-4 National ID: Service Date: 01-Mar-2024 Radiology: Covered Patent's Tel No: 0585877324 Threshold Policy Holder: Limit: Payer Name: MetLife Class: Normal Out-Patent: Patent's File **Category B** 42644 Pharmacy: Co-Part: 20% Category: No: Gatekeeper: Laboratory: No Consultation: Covered Referral No: Referred

SUBJECTIVE ASSESSMENT

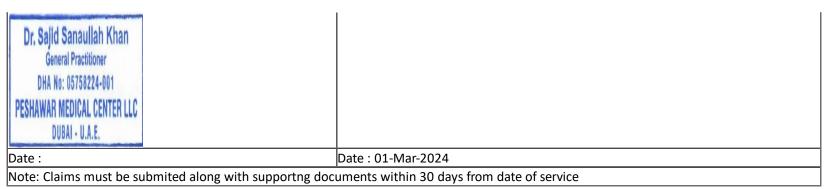
Service:

Symptom(s) as described by the patent (Chief Complaint):	Date of Symptoms/illness started			
Complaint	DD	ММ	YYYY	
C/o: Had fever yesterday for which he took ibuprofen				
Now feels well but has decided to come take sick leave as requested by the company				
Not a known hypertensive and not diabetic and has no other medical condition of note.				
There are no known drug allergies.				

ClinicSoft 8.0 -	NextCare Form
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Complaint												
Current medications include ibuprofen and strepsil only.												
He does not have any symptoms right now except for mild throat pain.												
								Date o	Date of Symptoms/illness started			
Past Medical	Surgical Histo	al History? Yes No				DD	MM	YYYY				
								Data o	f Symptom	s/illness started		
Obs/Gyn Cla	ims							DD	MM	YYYY		
☐ Para	Gravida:		AB:	LMP:	Marital Status	S:	Marital Date:					
	I the Patient firs											
ls the Patient	under any type	of Treat	ment? O	Yes O No	if yes, indicat	te what Asse	essment and since w	/hen:				
	ASSESSMEN	T <i>(To b</i> e	completed	by Physician)								
Clinical Find	ings :				I	Vital Signs : RR : 16	B/P: 112	T:36.8	HR:	82		
Assessment II	/Diagnosis : NDICATE DIAG	O A		Chronic PTOM	O Confirm	ed OSu	spected					
Туре		Code		Diagnosis	Diagnosis							
Primary		J06.9		Acute uppe	r respiratory ir	nfection, uns	pecified					
Secondary		R07.0		Pain in throat								
Secondary		R50.9		Fever, unspecified								
ACCIDENT/C	CCUPATIONAL	Claim	Informato	n (complete	if claim is a re	sult of accid	lent or work related	d illness/inju	ry)			
					Injury due							
Accident or illness due to work?			to road accident?	Describe how the accident or work related injury/illness occur:								
○ Yes ○ No				O Yes O								
Date of accident or beginning of illness:						<u> </u>						
MEDICAL PL	AN Itemized Or	riginal Ir	nvoices an	d Applicable	Prescriptions ,	/ Reports / F	Results must be encl	osed to cons	ider claim			

CPT Code Treatment				Туре			Price			
9	CONSUL	TATION GP			General Consultation		25.0000			
Code	Generic			Duration I			Instructions	Instructions		
0195-123701-0391	(CETIRIZINE	HCL : 10 MG) F	FILM COATED TA	OATED TABLETS				Take 1Tablets 1Time(s) perDay For 10 Day(s) evening		
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACI (PSEUDOEPHEDRINE : 30 MG) FILM CO							Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal		
O Pharmacy:		Estmated Costs O Laboratory / Ra			O Laboratory / Radio	ology:	Estmated Co	osts		
		•	O Surgery:	0	Endoscopy:					
Is the following required Physi			O Physiotherapy:	therapy: Other Procedures:						
					s please specify					
ls In-patient Required ?	Length of Stay	1		Indicate Provider				Estimate Cost		
I hereby certfy that all informaton mentoned are correct & the the medical services shown on this form were medically indicated & necessary for the management of this case. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizato to release any information regarding my medical condition and history to NEXtCAF for the purpose of determining insurance benefits. Medical management is the solution to responsibility of doctor and the patent.							d history to NEXtCARE			
Treating Physician Name : Sajid Sanaullah					,					
Tel / Fax (important):										
Signature & Stamp	las		Patient's	Signa	ature(Parent if minor)					



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